STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505474	A. BUILDING _____ B. WING _____	C 09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA AND MARY HEALTH SERVICE	19160 FRONT STREET NORTHEAST POULSBO, WA 98370

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Marth and Mary Health Services on 9/5/13 & 9/6/13. The sample included 6 current residents out of a census of 156. The following are complaints investigated as part of this survey: #2848315 #2868370 The survey was conducted by: [redacted] RN, MN The surveyor is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Unit A 1949 South State Street, MS: N27-24 Tacoma, Washington, 98405-2850 Telephone: (253) 983-3800 Fax: (253) 589-7240 [signature] 9/17/13 Residential Care Services Date	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 30 Sep 2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F225:** Facility interviewed two additional residents during investigation to rule out abuse and/or neglect related to incident of Resident #2. Facility will contact Resident #2's husband regarding participation in Resident #2's care and will provide education, including risks and benefits, and training for on-going participation if desired. Facility will review Resident #2's behavior care plan and ensure it includes direction to staff for personal care approaches and interventions consistent with Resident #2's care needs. Facility counseled Staff C regarding reporting allegations of abuse and neglect. Facility will review performance of Staff F in accordance with updated Investigation Policy & Procedure. Facility will open investigations regarding two other residents referenced during investigation including contacting the State Hotline, logging allegations and interviewing an expanded sample of residents to rule out abuse and/or neglect. Facility will update Investigation Policy & Procedure to include on-going monitoring of staff performance/conduct following an unsubstantiated allegation of abuse/neglect. Continued on Page 3 of 6	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to thoroughly investigate 1 of 4 Residents (Resident #2) reviewed for actual/potential abuse and/or neglect. The facility failed to thoroughly investigate a witnessed incident of inappropriate verbal communication. The facility also failed to report to the state agency and investigate allegation of abuse and or neglect by two other residents. This failure placed residents at risk for further abuse and or neglect. Findings include: Resident #2 admitted to the facility on [redacted]/13 with multiple diagnoses to include [redacted] disease. Review of the facility's "QA Incident Investigation Form" dated 7/23/13 revealed the licensed nurse (Staff G) went in Resident #2's room to give medication and noticed the resident had a bruise with bleeding on the posterior left hand. When asked what happened, the resident stated, "Your nursing assistant happened." The nursing assistant (Staff C) reported to the licensed nurse that she entered Resident # 2's room and heard the nursing assistant (Staff F) and the resident yelling at one another, and the yelling was loud and argumentative. According to the facility's investigation, Staff C also stated that two other residents had complained that (Staff F) was too rough when providing care. Although Staff F was immediately suspended pending investigation, review of the investigation conducted by licensed nurse (Staff B) did not	F 225	Continued from Page 2 of 6 Facility will in-service staff regarding abuse/neglect identification, reporting, investigation including mandatory reporting responsibility and changes to Facility Investigation Policy & Procedure. Facility Interdisciplinary Team (IDT) will review incidents quarterly and report findings to QAPI Committee for further follow-up. Corrective action will be completed by 21 Oct 2013. DNS and Administrator will ensure on-going compliance.	

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F 225	Continued From page 3 reveal evidence the facility expanded resident interviews at the time. Further review did not reveal the allegation of rough handling by the two other residents had been reported or investigated. During an interview on 9/6/13 at 12:13 p.m., with the licensed nurse (Staff B) and with the Administrator (Staff A), Staff B confirmed she did not expand resident interviews for the investigation regarding Resident #2. Staff B also confirmed that the incident regarding the two residents who allegedly reported rough handling had not been reported to the state agency and had not been investigated.	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to implement interventions to reduce hazards and risk for 1 of 3 residents (Resident #1) reviewed for accidents and supervision. This failure placed the resident at risk for further injury.	F 323	**F323:** Facility updated Resident #1's care plan on 26 Sep 2013 with enhanced directions regarding repositioning and bed mobility. Facility has requested a Physical Therapy consult regarding safe/appropriate bed mobility assistance and will update care plan accordingly. Facility will also schedule care conference with Resident #1 regarding history of self-directed care and will review repositioning/bed mobility care and plan to prevent fractures related to primary diagnosis. Residents who have been assessed as "high risk" for fracture will be reviewed and care plans updated as appropriate. Facility will in-service nursing staff regarding requirement to follow resident care plans. Facility Interdisciplinary Team (IDT) will review incidents quarterly and report findings to QAPI Committee for further follow-up. Continued on Page 5 of 6	

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F 323	Continued From page 4 Findings include: Resident #1 had a current admit date of [redacted]/13 with multiple diagnoses to include [redacted] The MDS, an assessment tool, dated 3/10/13 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The care plan with a goal date of 9/13/13 documented the resident required the assist of two people for bed mobility and transfers. The nursing note dated 7/23/13, documented in part, "Resident up in w/c in the morning. Around 1:20 she called for a nursing assistant to assist her to bed as she was having pain related to her kidney stones. She was assisted to bed via hoyer lift by nursing assistant (Staff H) and nursing assistant Staff D." Review of the facility's "QA Incident Investigation Form" documented, in part, "as the aide was removing the sling from under the resident, the resident told them rather than rolling her, she wanted to hold the aide's hand and sit up. The resident was asked if she was sure and the resident said yes. Just as she started to sit up the resident said my leg broke again." A drawing by staff D of what occurred revealed Staff H was on one side of the bed away from the resident, and Staff D was on the other side of the bed assisting the resident with repositioning. Review of Staff D's written statement documented, "as we went to move the sling from under the patient she told us that rather than	F 323	Continued from Page 4 of 6 Corrective action will be completed by 21 Oct 2013. DNS and Administrator will ensure on-going compliance.	

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F 323	Continued From page 5 rolling she wanted to hold my hand and sit up, I asked if she was sure and she said yes just as she started to sit up she said her leg broke again." On 9/5/13 at 1:32 p.m., during an interview, Resident #1 stated she was being repositioned in bed with the assist of one person (Staff D). The resident stated she told Staff D to give her his hand and she would pull herself up. Resident #1 stated she was moving slow, and the aide must have thought she needed more help, so he pulled on her which resulted in a re-injury to her leg. On 9/6/13 at 12:04 p.m., during an interview, Staff H stated after she helped Staff D assist the resident to bed, she walked around to move a chair, and heard the resident scream out, "my leg is broken." Staff H reported, the resident did not have the assist of two people when she screamed out, but was assisted by Staff D only. Review of the medical imaging report from the hospital revealed in part, "A focal deformity and depression in the anterior aspect of the distal shaft of the right femur is seen, which is likely secondary to the old fracture which may be healing. However, a small acute superimposed fracture cannot be excluded." On 9/6/13 at 11:52 a.m., during an interview with the Administrator (Staff A) and with the licensed nurse (Staff E), Staff E stated the resident required the assist of two people with bed mobility and with transfers. Staff E reported while one person assist to reposition the resident, the other person should guide the resident's injured leg.	F 323	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	